



Confidential Patient Information

Dr. Jason Hulme

100 Bluegrass Commons, Suite 150

Hendersonville, TN 37075

ph: (615)537-5520 | fax: (615)537-5521

Auto Accident: Additional Information Form

Is Today's visit due to an automobile injury: Yes No

Date Of Injury: _____

Responsible Party Information:

Responsible Party's Name: _____

Address: _____

Responsible Party's Insurance Company: _____

Adjustor: _____ Phone Number: _____

Claim Number: _____

Attorney Information: I have retained an attorney: Yes No

Attorney's Name: _____ Phone Number: _____

Address: _____

Accident Information:

Date of Accident: ____/____/____ Time of Day: _____ Were there witnesses?: Yes No

Names of Witnesses: _____

Were you?: Driver Passenger Front Seat Back Seat

Number of People in your vehicle: _____ Were you wearing seatbelt?: Yes No

What directions were you headed: North South East West

On what street: _____

What direction was the other vehicle headed: North South East West

On what street: _____

Were you struck from: Front Behind Left Right

Approximate Speed of your car ____ mph Other car's approx speed ____ mph

Were you knocked unconscious? Yes No If yes, for how long? _____

Were the police notified? Yes No

In your own words, please describe the accident:



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Auto Injury Form Continued

Did you have any physical complaints BEFORE THE ACCIDENT? Yes No

If yes, please describe: _____

Please describe how you felt:

A. DURING the accident: _____

B. IMMEDIATELY AFTER the accident: _____

C. LATER THAT DAY: _____

D. THE NEXT DAY: _____

Do you have any congenital (from birth) factors which relate to this problem? Yes No

If yes, please describe: _____

Do you have any previous illness which relate to this case? Yes No

If yes, please describe: _____

Have you ever been involved in an accident before? Yes No If yes, please describe, including

date(s) and type(s) of accidents, as well as injury(ies) received: _____

Where were you taken after the accident? _____

Have you had X-rays/MRIs since the accident? Yes No Specify _____

Have you been treated by another doctor since the accident? Yes No

Doctor's Name(s): _____

Have you lost time from work due to of this accident? Yes No If yes, please complete following:

Last Day Worked: ___/___/___

Type of Employment: _____ Present Salary: _____

Are you being compensated for lost work: Yes No

Do you notice any activity restrictions as a result of this injury? Yes No

If yes, please describe: _____

Other pertinent information:



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PERSONAL INJURY PAYMENT POLICY

Active Spine and Joint Center will occasionally accept patients who have been injured in a motor vehicle accident or other liability injury; however the decision is up to the provider whether or not to see an injured patient. There is no guarantee for payment even if the injury is covered under a first-party payer. Active Spine and Joint Center has the right to be reimbursed for any medical benefits from the proceeds of any personal injury policy (PIP), Medpay, uninsured or underinsured motorist coverage, or workers compensation coverage's applicable to this incident.

The patient is ultimately responsible for all balances owed on their account. Active Spine and Joint Center may agree to accept a payment plan according to ASJC's policy if the patient is unable to pay the balance in full.

Your insurance company may choose to submit payment for your medical costs directly to you to disperse accordingly – do not assume they will directly pay this claim for you. Payment should be made within 30 days payable to 'Active Spine and Joint Center'. If you are unable to pay in full please contact Cassie Hulme at 615-537-5520 to make necessary arrangements as we do understand that sometimes insurance companies may take longer to process claims, especially for complex injuries.

While we do not wish to do so, failure to pay or agree to a payment plan within 60 days of the above statement will result in your account being placed with a collections company.

ADDITIONAL INFORMATION FOR 3RD PARTY INSURANCE BILLING

In most cases, third party insurance companies will not consider your claim until you have completed and been dismissed from care. This means it is *very* important to attend all appointments as recommended by your physician; cancelled and missed appointments may affect your ability to qualify for insurance reimbursement.

It is the responsibility of the patient to inform their assigned insurance adjuster that they are seeking medical care for injuries sustained. It is also the responsibility of the patient to inform their assigned adjuster when they have completed care and to send a request for your records.

It is our policy for third party insurance to hold all statements and billing until you have been dismissed from care or reached maximum clinical improvement. Upon dismissal by our physician or abandonment of your recommended treatment we will submit your final bill directly to you. At this time we recommend contacting your insurance adjuster to notify you have completed care and are ready to settle your claim.

Payment should be made directly to Active Spine and Joint Center within 30 days of dismissal.

Signature

Date